

Return Application With
Check Payable To:
Treasurer – State of NH
Application Fee: \$250

State of New Hampshire
Board of Pharmacy
121 South Fruit Street
Concord, NH 03301-2412
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

Board Use Only

JULY 1, 2015 TO JUNE 30, 2016 LICENSING PERIOD

APPLICATION FOR PERMIT – RESEARCH ORGANIZATION

HANDLING PRESCRIPTION DRUGS AND/OR ACTIVE PHARMACEUTICAL INGREDIENTS PER NH RSA 318:51-c

Location Of Research Organization / Actual Facility Location Where Drug Products Are Tested / Researched:		
Company Name: _____		
Street Address: _____		
City / State / Zip: _____		
Telephone: _____	E-Mail Address: _____	
Parent Company (If none, write 'None'): _____	State Of Incorporation (If Corp.): _____	
Name of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title of Officers). Attach Additional Sheet If Necessary.		
Name	Address	Title
Name	Address	Title
Name	Address	Title
Is the above referenced company licensed by the board of pharmacy in the state of location? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Within the last 5-years</u> , has a registration or licensure granted to the above referenced company or any of its owners, managing officers, or researchers by <u>any</u> state or federal agency been suspended, revoked, or otherwise disciplined? <input type="checkbox"/> Yes * <input type="checkbox"/> No * (If "Yes", attach a detailed explanation, along with copy of legal documentation of discipline)		
Provide the name, title, email, & business mailing address of the person to whom the permit, future renewal applications, and all Board communications should be directed:		
Name: _____	Title: _____	Tel. #: _____
E-Mail Address: _____		
Mailing Address: _____		

Categories of drug product being handled / researched?		
<input type="checkbox"/> Human Prescription Drugs	<input type="checkbox"/> Veterinary Prescription Drugs	<input type="checkbox"/> Other _____

APPLICATION CONTINUED ON NEXT PAGE ➡

Attachments & Declaration / Signature By Company Representative:

I affirm that I am the person authorized to sign this application for licensure and affirm that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.

ATTACHMENTS:

- ☐ 1. If licensed by your home-state Board of Pharmacy, submit a copy of the company's current license / registration – if your home state does not require licensure of research organizations, please write N/A here: _____
- ☐ 2. If licensed and inspected by your home-state Board of Pharmacy, submit a copy of the facility's most recent inspection report – if your home state does not require licensure of research organizations or did not inspect your facility, please write N/A here: _____

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE N/A & THE REASON IT DOES NOT APPLY.

**ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM
MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 15 DAYS.**